Optum

Coding &
Payment Guide

Medical Oncology/ Hematology Services

An essential coding, billing and reimbursement resource for oncology and hematology services

2024

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Contents

Getting Started with Coding and Payment Guide

The *Coding and Payment Guide for Medical Oncology/Hematology Services* is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and services and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to oncology and hematology are listed first in the *Coding and Payment Guide*. All other CPT/HCPCS codes in *Coding and Payment Guide* are listed in ascending numeric order, including surgery, radiology, laboratory and medicine codes. Each CPT/HCPCS code is followed by its official code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes are not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum *Coding and Payment Guide* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service to a series of similar procedures/services. Following the specific HCPCS Level II and CPT code(s) and its narrative is a combination of features.

Appendix Codes and Descriptions

Some CPT codes that are not commonly used in Oncology/Hematology, are presented in a less comprehensive format in the appendix, followed by an easy-to-understand explanation.

CCI Edits, RVUs, and Other Coding Updates

The *Optum Coding and Payment Guide* includes the list of codes from the official Centers for Medicare and Medicaid Services' *National Correct Coding Policy Manual for Part B Medicare Contractors* that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from the version 28.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is https://www.optumcoding.com/ProductUpdates/. The 2024 edition password is: **XXXX**. Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

Bone
Marrow
Aspiration, 38220, 38222
Biopsy, 38221-38222
Harvesting, 38230-38232
Allogeneic, 38230
Autologous, 38232

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiv of the CPT book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified healthcare professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Facilities

Many of the procedures and services in this *Coding and Payment Guide* are performed in an outpatient department of a hospital or in free standing outpatient facilities. In some instances the coding and or payment requirements are different than that reported by a healthcare provider. When the information provided is specific to the facility, the term **Facility Reporting**, will precede the facility-specific information provided.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting. Because payment guidelines may vary by payer to payer or even geographical

location, only the drugs or other complex drug or highly complex biologic agents are provided in this *Guide*.

Professional and Technical Component

Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and the patient is sent to an outside testing facility, modifier 26 must be appended to the procedural code to indicate the clinician performed only the professional component.

Similarly, when only a technical component is performed, without the professional interpretation service, such as by a facility, modifier TC should be appended to the appropriate code. In those instances when both the professional and technical components are provided, no modifier is required.

Specialty-Specific Guidelines

Injections, Infusions, and Chemotherapy

A concurrent infusion is the administration of multiple infusions at the same time through the same IV line. Sequential infusions describe administration of multiple drugs that are administered immediately following another infusion. Sequential and additional hours refer to continued services through the same vascular site.

Example

If drug A is administered at the same time as drug B using the same IV line with Y connector, the drug B infusion is concurrent. If drug B was administered through the same IV line, but after the drug A infusion finished, then drug B infusion is sequential.

Note: Sequential and additional infusion hours may be more difficult to track particularly when a patient moves between hospital departments.

CMS allows only one initial drug administration service per encounter for each vascular site, regardless of the types of infusion services provided. Additional medications administered through those vascular sites should be reported with the sequential, concurrent, or additional hour codes. Although CPT guidelines differ regarding the initial administration, CMS will continue to adhere to its current guidelines. If an infusion or injection is of a subsequent or concurrent nature, report the drug administration code as subsequent or concurrent even if it was the first drug administered.

Example

If using the same IV line and an IV push drug is administered first but the main encounter is for a chemotherapy infusion, the chemotherapy infusion is reported as the initial infusion and the IV push is reported as sequential. When protocol requires two different vascular sites for drug administration or when the route of administration is different, more than one initial drug administration codes may be reported.

Official hierarchy has been developed by CMS for facility reporting of drug administration and is followed by most payers for physician administration as well. The following hierarchy applies: chemotherapy services are primary over therapeutic, prophylactic, or diagnostic services, which are primary over hydration services. Infusions are primary to pushes, which are primary to injections.

Chemotherapy Hierarchy

- Chemotherapy Infusions
- Chemotherapy Injections
- Therapeutic, prophylactic and diagnostic infusions
- Therapeutic, prophylactic and diagnostic intravenous pushes—IVP
- Hydration

Note: Chemotherapy services are always primary and will always be reported as the initial administration when performed.

When timing an infusion for reporting purposes, use the actual time that the infusion was administered and documented. Additional hour add-on codes should be reported only when an infusion runs more than 30 minutes.

Example

An infusion that runs 1 hour and 20 minutes is reported only with the initial hour drug administration code. If the infusion was administered over 91 minutes (1 hour and 31 minutes), then the initial hour infusion would be reported as well as one additional hour add-on code. Infusions that are of 15 minutes duration or less should be reported as an intra-arterial or intravenous push injection.

Facility Reporting

For facilities reporting drug administration affective January 1, 2018, low-cost drug administration services are unconditionally packaged. CMS determined based on its analysis of claims data that the geometric mean cost for APC 5691 Level 1 Drug Administration, is approximately $40 and the geometric mean cost for APC 5692 Level 2 Drug Administration, is approximately $63. Additionally, Medicare data show that these drug administration services are currently being provided as part of another separately payable service for which two separate payments are made, and support that packaging these services when they are reported with another separately payable service, is appropriate. Drug administration services assigned to APC 5693 Level 3 Drug Administration, and APC 5694 Level 4 Drug Administration, are not being packaged.

The following procedures are unconditionally packaged:

APC 5691—Level 1 Drug Administration

96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion

96542

96542 Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents

Explanation

The physician or supervised assistant prepares and administers a chemotherapeutic medication to combat malignant neoplasms or microorganisms. This code applies to medication infused into the central nervous system through a catheter leading from a subcutaneous reservoir of medication in the brain's subarachnoid or intraventricular space.

Coding Tips

For radioactive isotope therapy, see 79005. For subcutaneous or intramuscular administration of chemotherapy, nonhormonal, antineoplastic, see 96401; hormonal, antineoplastic, see 96402. For intralesional chemotherapy administration, up to and including seven lesions, see 96405; more than seven lesions, see 96406. To report intravenous chemotherapy, push technique, single or initial substance/drug, see 96409; each additional substance or drug, see 96411. For chemotherapy administration, via IV infusion technique, up to one hour, single or initial substance/drug, see 96413; each additional hour, report 96415 in addition; initiation of prolonged chemotherapy involving more than eight hours, requiring the use of a portable or implantable pump, see 96416; each additional sequential infusion thereafter, up to one hour, report 96417. For provision of a chemotherapy agent, see the appropriate HCPCS Level II code. Medicare and some other payers may require HCPCS Level II codes Q0083, Q0084, and Q0085 be reported for this service.

Documentation Tips

Documentation should include the direct supervision as well as special considerations for preparation, dosage or disposal, frequent monitoring, and any complications that occur. The documentation must indicate the substance, dosage, and administration.

Reimbursement Tips

Preauthorization of these services may be required. Check with the specific payer to determine benefits specific to cancer treatment, as well as with the patient regarding any supplementary cancer policies.

ICD-10-CM Diagnostic Codes

C71.0	Malignant neoplasm of cerebrum, except lobes and ventricles
C71.1	Malignant neoplasm of frontal lobe
C71.2	Malignant neoplasm of temporal lobe
C71.3	Malignant neoplasm of parietal lobe
C71.4	Malignant neoplasm of occipital lobe
C71.5	Malignant neoplasm of cerebral ventricle
C71.6	Malignant neoplasm of cerebellum
C71.7	Malignant neoplasm of brain stem
C71.8	Malignant neoplasm of overlapping sites of brain
C79.31	Secondary malignant neoplasm of brain
C79.49	Secondary malignant neoplasm of other parts of nervous system
Z51.11	Encounter for antineoplastic chemotherapy

Associated HCPCS Codes

Q0083	Chemotherapy administration by other than infusion technique only (e.g., subcutaneous, intramuscular, push), per visit
Q0084	Chemotherapy administration by infusion technique only, per visit
Q0085	Chemotherapy administration by both infusion technique and other technique(s) (e.g. subcutaneous, intramuscular, push), per visit

AMA: **96542** 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96542	0.75	2.89	0.08	3.72
Facility RVU	**Work**	**PE**	**MP**	**Total**
96542	0.75	0.38	0.08	1.21

	FUD	Status	MUE	Modifiers				IOM Reference
96542	N/A	A	1(3)	N/A	N/A	N/A	80*	100-03,110.2; 100-04,4,230.2

* with documentation

Terms To Know

chemotherapy. Treatment of disease, especially cancerous conditions, using chemical agents.

direct supervision. Situation in which the physician must be present in the office suite and immediately available to provide assistance and direction throughout a given procedure. The physician is not, however, required to be present in the room when the procedure is performed.

intraventricular space. Fluid-filled areas near the center of the brain that are within the ventricles.

subarachnoid. Space located between the arachnoid membrane and the pia mater that contains cerebrospinal fluid.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding and Payment Guide for Medical Oncology/Hematology* is updated with CPT and HCPCS codes for year 2023. The following icons are used in the *Coding and Payment Guide*:

- ● This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same provider on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services

Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96160	96161	97802	97803	97804
99406	99407	99408	99409	99497	99498	

- **[ ]** CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

2. Explanation

Every CPT/HCPCS code or series of similar codes is presented with its official code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding and Payment Guide for Medical Oncology/Hematology*, a step-by-step clinical description of the procedure is provided, in simple terms. Technical language that might be used by the medical or radiation oncologist is included and defined. *Coding and Payment Guide for Medical Oncology/Hematology* describes the most common treatments.

3. Coding Tips

Coding tips provide information on how the code should be used, provide related procedure codes, and offer help concerning common billing errors and modifier usage. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

4. Documentation Tips

Documentation tips provide code-specific tips to the coder regarding the information that should be noted in the documentation in order to support code assignment.

5. Reimbursement Tips

Reimbursement tips offer Medicare and other payer guidelines that could affect the reimbursement of this service or procedure.

6. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- **N** Newborn: 0
- **P** Pediatric: 0-17
- **M** Maternity: 9-64
- **A** Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances, the ICD-10-CM codes for only one side of the body may have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to a right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

7. HCPCS Associated Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

8. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

9. Relative Value Units/Medicare Edits

The 2023 Medicare edits were not available at the time this book went to press. Updated 2023 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2023 edition password is **23SPECIALTY**.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

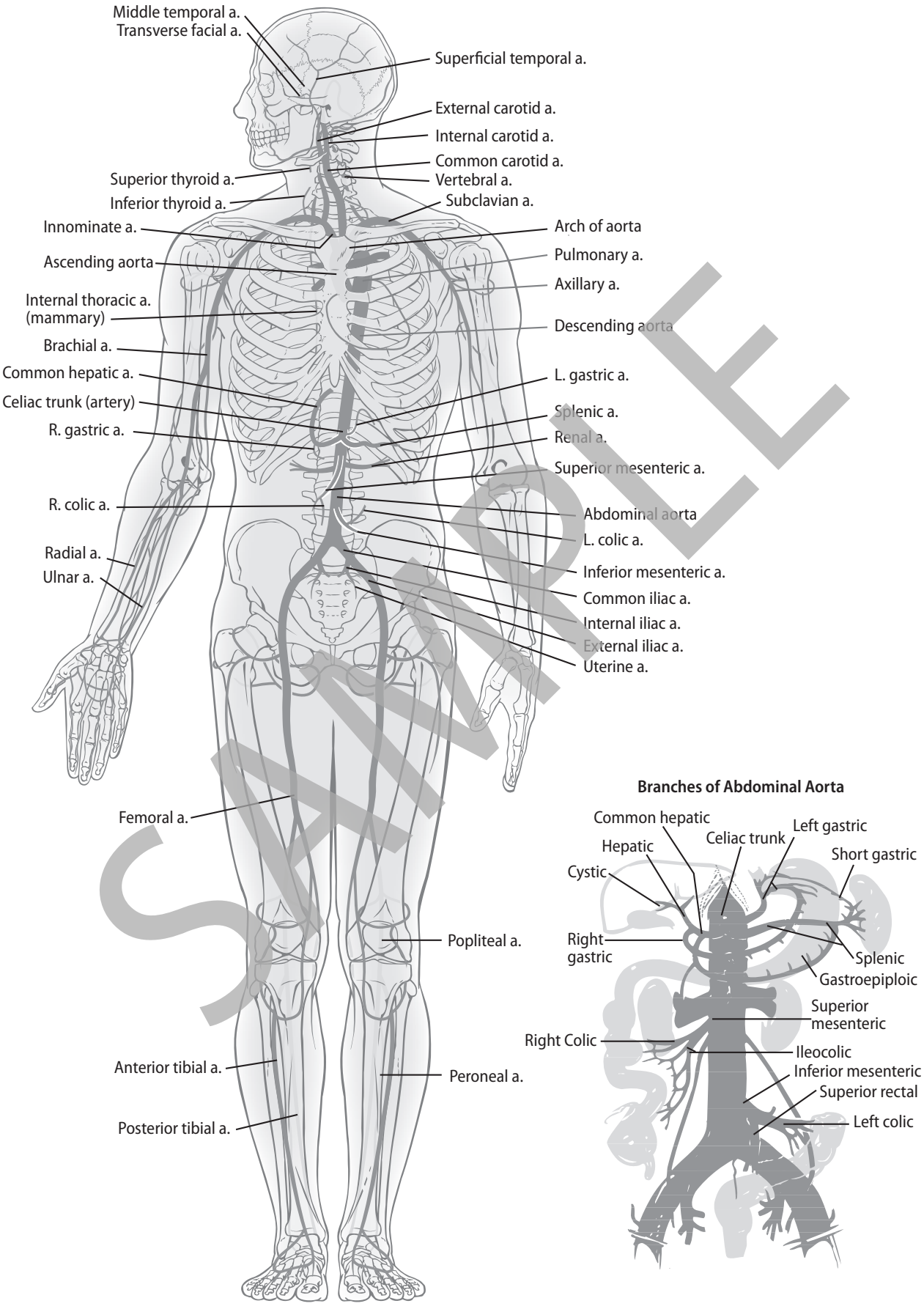
- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) insurance component, reflecting the relative risk or liability associated with the service

There are two groups of RVUs listed for each CPT code. The first RVU group is for nonfacilities, which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The second RVU group is for facilities, which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities.

Medicare Follow-Up Days (FUD)

Information on the Medicare global period is provided here, even though it is not relevant to oncologist or hematologists' coding. These services, then, have a value of 0. The global period includes all the necessary services normally furnished before, during, and after a

Arterial System



Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

▶The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◀

Classification of Evaluation and Management (E/M) Services

▶The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◀

New and Established Patients

▶Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

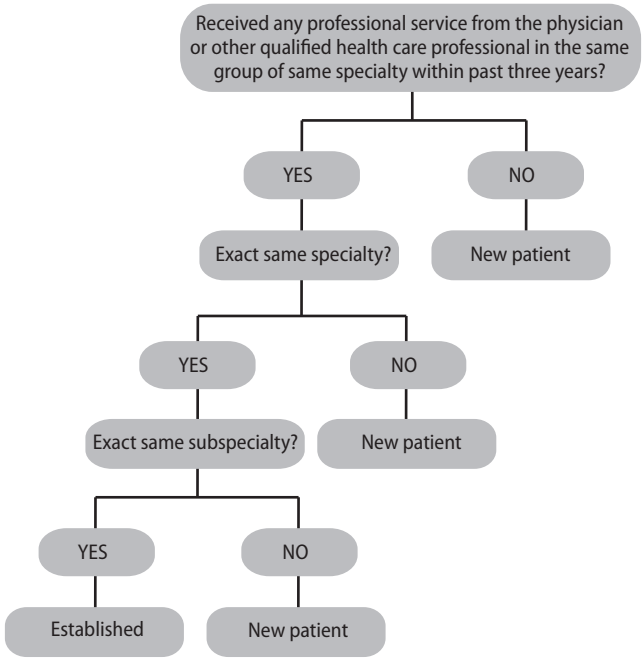
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.◀

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

▶◀ = Contains new or revised text

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

Documentation Tips

Medicare allows only the medically necessary portion of the visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level of an E/M code. Medical necessity must be clearly stated and support the level of service reported.

Reimbursement Tips

The place-of-service (POS) codes used for reporting these services are the same as those for a new patient: POS code 11 represents the clinician's office environment and POS code 22 represents the outpatient setting. When a separately identifiable E/M service is reported at the same time as another procedure or service, modifier 25 should be appended to the E/M service to indicate the service is distinct from the other service performed.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

36640

36640 Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown

Explanation

The physician accesses the artery supplying the area to be treated. To insert a cannula, or tube-shaped portal for prolonged infusion therapy, the physician makes an incision above the artery and dissects the surrounding tissue to access it. The artery is sometimes nicked with a thin-bladed scalpel before the physician inserts the catheter. The catheter may be advanced to a site immediately upstream of the site to be treated. This catheter acts as a portal for the infusion of chemotherapy drugs and will remain in place until chemotherapy is completed. The catheter is removed, the hole in the artery is repaired, and the incision is repaired with a layered closure.

Coding Tips

Report 36640 in addition to intra-arterial chemotherapy treatment (96420–96425) when provided during the same encounter. For arterial catheterization for occlusion therapy, see 75894. Supplies used when providing this procedure may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

Reimbursement Tips

When 36640 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
36640	2.1	1.14	0.14	3.38
Facility RVU	**Work**	**PE**	**MP**	**Total**
36640	2.1	1.14	0.14	3.38

	FUD	Status	MUE	Modifiers				IOM Reference
36640	0	A	1(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

arterial catheterization. Introduction of a narrow, hollow tube within an artery to allow for therapeutic or diagnostic proceedings, such as visualization inside the lumen, measurement of arterial pressures, injections, or repair.

chemotherapy. Treatment of disease, especially cancerous conditions, using chemical agents.

cutdown. Small, incised opening in the skin to expose a blood vessel, especially over a vein (venous cutdown) to allow venipuncture and permit a needle or cannula to be inserted for the withdrawal of blood or administration of fluids.

infusion. Introduction of a therapeutic fluid, other than blood, into the bloodstream.

36823

36823 Insertion of arterial and venous cannula(s) for isolated extracorporeal circulation including regional chemotherapy perfusion to an extremity, with or without hyperthermia, with removal of cannula(s) and repair of arteriotomy and venotomy sites

Explanation

The physician inserts arterial and venous cannula(s) for isolated extracorporeal circulation to an extremity to provide regional perfusion chemotherapy (RPC) with or without hyperthermia. The external iliac, common femoral, or subclavian artery and vein are isolated depending on the site of the tumor. A cannula is inserted into the selected artery and vein to isolate blood flow to and from the extremity. The blood flow from the isolated extremity is connected to a perfusion pump where the blood is oxygenated. The blood may be heated to between 40°-40.5° C (104°-105° F). One or more high dose chemotherapy agents are injected and perfused over an hour or more with flow rates monitored and adjusted to minimize leakage into the systemic circulation. The combination of heat and the chemotherapy agent act to destroy the cancer cells. After completion of the perfusion procedure, the cannula(s) are removed and the artery and vein repaired.

Coding Tips

Chemotherapy perfusion supported by a membrane oxygenator/perfusion pump is included in 36823. Do not report chemotherapy administration codes 96409–96425 in conjunction with 36823. Chemotherapy drugs and supplies are reported separately.

Documentation Tips

The name of the agent, the dosage, as well as stop and start times should be clearly identified and notated in the medical record with as much specificity as possible.

ICD-10-CM Diagnostic Codes

C40.01 Malignant neoplasm of scapula and long bones of right upper limb ☑

C40.02 Malignant neoplasm of scapula and long bones of left upper limb ☑

C40.11 Malignant neoplasm of short bones of right upper limb ☑

C40.12 Malignant neoplasm of short bones of left upper limb ☑

C40.21 Malignant neoplasm of long bones of right lower limb ☑

C40.22 Malignant neoplasm of long bones of left lower limb ☑

C40.31 Malignant neoplasm of short bones of right lower limb ☑

C40.32 Malignant neoplasm of short bones of left lower limb ☑

C40.81 Malignant neoplasm of overlapping sites of bone and articular cartilage of right limb ☑

C40.82 Malignant neoplasm of overlapping sites of bone and articular cartilage of left limb ☑

C43.61 Malignant melanoma of right upper limb, including shoulder ☑

C43.62 Malignant melanoma of left upper limb, including shoulder ☑

C43.71 Malignant melanoma of right lower limb, including hip ☑

C43.72 Malignant melanoma of left lower limb, including hip ☑

C47.11 Malignant neoplasm of peripheral nerves of right upper limb, including shoulder ☑

C47.12 Malignant neoplasm of peripheral nerves of left upper limb, including shoulder ☑

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

77316-77318

77316 Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)

77317 intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)

77318 complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)

Explanation

Brachytherapy is the application of radioactive isotopes for internal radiation therapy that is used to treat cancer. Some radioactive material is encapsulated in metal seeds, wires, tubes, or needles for intracavitary or interstitial implantation and some are prepared in solutions for instillation or oral administration. Sealed sources are inserted by the physician in or around the tumor. Sources are intracavitary or permanent interstitial placements and ribbons are temporary interstitial placements. Brachytherapy gives greater control over localized malignancy while preserving function and reducing damage to surrounding tissue. Brachytherapy isodose plans are necessary to determine the amount of radiation that the tumor will absorb and the distribution of radiation around the sources. Report 77316 for a simple calculation made from one to four sources/ribbons or remote afterloading, one channel. Report 77317 for an intermediate calculation made from five to 10 sources/ribbons or remote afterloading, two to 12 channels. Report 77318 for a complex calculation made from more than 10 sources/ribbons or remote afterloading, more than 12 channels. These codes include basic dosimetry calculations.

Coding Tips

A treatment area is a contiguous anatomic location that will be treated with the radiation therapy. Discontinuous anatomic locations should be considered as distinct and separate treatment areas. However, if the patient's treatment plan is significantly revised, it may be necessary to prepare a new isodose plan for brachytherapy for the same treatment area. In these instances, when supported by medical necessity, the appropriate CPT code may be reported a second time. Check with third-party payers for their requirements. These codes should not be reported with basic radiation dosimetry calculations (77300). Brachytherapy isodose planning should not be reported with radiation treatment delivery (77401), or high dose rate electronic brachytherapy (0394T or 0395T).

Documentation Tips

Whenever a patient's treatment plan is revised significantly, it may be necessary to prepare a new isodose plan for teletherapy or to perform new isodose calculations for brachytherapy. When such work is supported by medical necessity, report with the appropriate CPT codes.

Reimbursement Tips

These codes have both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier.

Preauthorization of these services may be required. Check with the specific payer to determine benefits specific to cancer treatment as well as with the patient regarding any supplementary cancer policies.

ICD-10-CM Diagnostic Codes

This code is associated with general malignancies and associated codes are too numerous to list here. Refer to the ICD-10-CM Neoplasm section.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
77316	1.4	5.62	0.09	7.11
77317	1.83	7.42	0.15	9.4
77318	2.9	10.23	0.2	13.33
Facility RVU	**Work**	**PE**	**MP**	**Total**
77316	1.4	5.62	0.09	7.11
77317	1.83	7.42	0.15	9.4
77318	2.9	10.23	0.2	13.33

	FUD	Status	MUE	Modifiers				IOM Reference
77316	N/A	A	1(3)	N/A	N/A	N/A	80*	None
77317	N/A	A	1(3)	N/A	N/A	N/A	80*	
77318	N/A	A	1(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

brachytherapy. Form of radiation therapy in which radioactive pellets or seeds are implanted directly into the tissue being treated to deliver their dose of radiation in a more directed fashion. Brachytherapy provides radiation to the prescribed body area while minimizing exposure to normal tissue.

dosimetry. Component in the administration of radiation oncology therapy in which a radiation dose is calculated to a specific site, including implant or beam orientation and exposure, isodose strengths, tissue inhomogeneities, and volume.

isotope. Chemical element possessing the same atomic number (protons in the nucleus) as another, but with a different atomic weight (number of neutrons).

radiotherapy afterloading. Part of the radiation therapy process in which the chemotherapy agent is actually instilled into the tumor area subsequent to surgery and placement of an expandable catheter into the void remaining after tumor excision. The specialized catheter remains in place and the patient may come in for multiple treatments with radioisotope placed to treat the margin of tissue surrounding the excision. After the radiotherapy is completed, the patient returns to have the catheter emptied and removed.

ribbons. In oncology, small plastic tubes containing radioactive sources for interstitial placement that may be cut into specific lengths tailored to the size of the area receiving ionizing radiation treatment.

seeds. Small (1 mm or less) sources of radioactive material that are permanently placed directly into tumors.

96401-96402

96401 Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic

96402 hormonal anti-neoplastic

Explanation

The physician or supervised assistant prepares and administers non-hormonal medication to combat diseases such as malignant neoplasms or microorganisms. These codes apply to medication injected under the skin (subcutaneous) or into a muscle (intramuscular) often in the arm or leg. Report 96402 for a hormonal medication administered to combat diseases such as malignant neoplasms or microorganisms.

Coding Tips

When the medical record documentation clearly identifies that it is medically necessary to separate a substance into two doses (i.e., two injections or infusions in different sites), it is appropriate to code both doses with modifier 59 or the appropriate X [E, S, P, U] modifier. The preparation of chemotherapy agent(s) is included in the service for administration of the agent and is not reported as a separate service.

To report the intramuscular or subcutaneous administration of antiemetics, narcotics, or analgesics, see 96372. The substance used when providing this procedure may be reported with the appropriate HCPCS Level II code. Verify the appropriate dosing requirements and units of service. Experimental or non-Food and Drug Administration (FDA) approved treatment may not be covered by the payer. Check with the specific payer for coverage guidelines or limitations. Examples of hormonal anti-neoplastics include degarelix (SC), infergen (SC), and triptorelin (IM).

When the encounter is solely for the administration of chemotherapy, immunotherapy, or radiation therapy, assign the appropriate code from category Z51 Encounter for other aftercare and medical care, as the principal or first-listed diagnosis. The specific malignancy code is assigned as a subsequent condition.

For intradermal cancer immunotherapy injection, see 0708T-0709T.

Documentation Tips

These services are considered highly complex and require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight and intraservice supervision of staff. Documentation should include the direct supervision as well as special considerations for preparation, dosage or disposal, frequent monitoring, and any complications that occur. Chemotherapy and other highly complex drugs or biologic agent administration involves advanced practice training and competency for all staff members involved in providing these services due to the significant degree of patient risk and ongoing monitoring involved with administering these medications.

Review the documentation to verify the route of administration. Intramuscular injections will note an injection site deep into a muscle in the arm, thigh, or buttock. Subcutaneous injections will be performed just under the skin.

Reimbursement Tips

Preauthorization of these services may be required. Check with the specific payer to determine benefits specific to cancer treatment, as well as with the patient regarding any supplementary cancer policies.

ICD-10-CM Diagnostic Codes

This code is associated with general malignancies and associated codes are too numerous to list here. Refer to the ICD-10-CM Neoplasm section.

AMA: **96401** 2022,May; 2018,Sep **96402** 2022,May; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96401	0.21	1.99	0.05	2.25
96402	0.19	0.77	0.02	0.98
Facility RVU	**Work**	**PE**	**MP**	**Total**
96401	0.21	1.99	0.05	2.25
96402	0.19	0.77	0.02	0.98

	FUD	Status	MUE	Modifiers				IOM Reference
96401	N/A	A	3(3)	N/A	N/A	N/A	80*	100-03,110.2; 100-03,110.6; 100-04,4,230.2
96402	N/A	A	2(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

antineoplastic. Any agent with the ability to inhibit the growth of new tumors by keeping the proliferation of malignant cells in check.

intramuscular. Within a muscle.

malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other body areas.

neoplasm. New abnormal growth, tumor.

subcutaneous. Below the skin.

Neoplasm Table

Note: The list below gives the code number for neoplasms by anatomical site. For each site there are six possible code numbers according to whether the neoplasm in question is malignant, benign, in situ, of uncertain behavior, or of unspecified nature. The description of the neoplasm will often indicate which of the six columns is appropriate; e.g., malignant melanoma of skin, benign fibroadenoma of breast, carcinoma in situ of cervix uteri. Where such descriptors are not present, the remainder of the Index should be consulted where guidance is given to the appropriate column for each morphological (histological) variety listed; e.g., Mesonephroma – see Neoplasm, malignant; Embryoma — see also Neoplasm, uncertain behavior; Disease, Bowen's – see Neoplasm, skin, in situ. However, the guidance in the Index can be overridden if one of the descriptors mentioned above is present; e.g., malignant adenoma of colon is coded to C18.9 and not to D12.6 as the adjective "malignant" overrides the Index entry "Adenoma — *see also* Neoplasm, benign, by site." Codes listed with a dash -, following the code have a required additional character for laterality. The tabular list must be reviewed for the complete code.

	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
Neoplasm, neoplastic	C80.1	C79.9	D09.9	D36.9	D48.9	D49.9
abdomen, abdominal	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
cavity	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
organ	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
viscera	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
wall — *see also* Neoplasm, abdomen, wall, skin	C44.509	C79.2	D04.5	D23.5	D48.5	D49.2
connective tissue	C49.4	C79.8-☑	—	D21.4	D48.1	D49.2
skin	C44.509	—	—	—	—	—
basal cell carcinoma	C44.519	—	—	—	—	—
specified type NEC	C44.599	—	—	—	—	—
squamous cell carcinoma	C44.529	—	—	—	—	—
abdominopelvic	C76.8	C79.8-☑	—	D36.7	D48.7	D49.89
accessory sinus — *see* Neoplasm, sinus						
acoustic nerve	C72.4-☑	C79.49	—	D33.3	D43.3	D49.7
adenoid (pharynx) (tissue)	C11.1	C79.89	D00.08	D10.6	D37.05	D49.0
adipose tissue — *see also* Neoplasm, connective tissue	C49.4	C79.89	—	D21.9	D48.1	D49.2
adnexa (uterine)	C57.4	C79.89	D07.39	D28.7	D39.8	D49.59
adrenal	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
capsule	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
cortex	C74.0-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
gland	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
medulla	C74.1-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
ala nasi (external) — *see also* Neoplasm, skin, nose	C44.301	C79.2	D04.39	D23.39	D48.5	D49.2
alimentary canal or tract NEC	C26.9	C78.80	D01.9	D13.9	D37.9	D49.0
alveolar	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
mucosa	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
ridge or process	C41.1	C79.51	—	D16.5	D48.0	D49.2
carcinoma	C03.9	C79.8-☑	—	—	—	—
lower	C03.1	C79.8-☑	—	—	—	—
upper	C03.0	C79.8-☑	—	—	—	—
lower	C41.1	C79.51	—	D16.5	D48.0	D49.2
mucosa	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C41.0	C79.51	—	D16.4	D48.0	D49.2
sulcus	C06.1	C79.89	D00.02	D10.39	D37.09	D49.0
alveolus	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
ampulla of Vater	C24.1	C78.89	D01.5	D13.5	D37.6	D49.0
Neoplasm, neoplastic — *continued*						
ankle NEC	C76.5-☑	C79.89	D04.7-☑	D36.7	D48.7	D49.89
anorectum, anorectal (junction)	C21.8	C78.5	D01.3	D12.9	D37.8	D49.0
antecubital fossa or space	C76.4-☑	C79.89	D04.6-☑	D36.7	D48.7	D49.89
antrum (Highmore) (maxillary)	C31.0	C78.39	D02.3	D14.0	D38.5	D49.1
pyloric	C16.3	C78.89	D00.2	D13.1	D37.1	D49.0
tympanicum	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
anus, anal	C21.0	C78.5	D01.3	D12.9	D37.8	D49.0
canal	C21.1	C78.5	D01.3	D12.9	D37.8	D49.0
cloacogenic zone	C21.2	C78.5	D01.3	D12.9	D37.8	D49.0
margin — *see also* Neoplasm, anus, skin	C44.500	C79.2	D04.5	D23.5	D48.5	D49.2
overlapping lesion with rectosigmoid junction or rectum	C21.8	—	—	—	—	—
skin	C44.500	C79.2	D04.5	D23.5	D48.5	D49.2
basal cell carcinoma	C44.510	—	—	—	—	—
specified type NEC	C44.590	—	—	—	—	—
squamous cell carcinoma	C44.520	—	—	—	—	—
sphincter	C21.1	C78.5	D01.3	D12.9	D37.8	D49.0
aorta (thoracic)	C49.3	C79.89	—	D21.3	D48.1	D49.2
abdominal	C49.4	C79.89	—	D21.4	D48.1	D49.2
aortic body	C75.5	C79.89	—	D35.6	D44.7	D49.7
aponeurosis	C49.9	C79.89	—	D21.9	D48.1	D49.2
palmar	C49.1-☑	C79.89	—	D21.1-☑	D48.1	D49.2
plantar	C49.2-☑	C79.89	—	D21.2-☑	D48.1	D49.2
appendix	C18.1	C78.5	D01.0	D12.1	D37.3	D49.0
arachnoid	C70.9	C79.49	—	D32.9	D42.9	D49.7
cerebral	C70.0	C79.32	—	D32.0	D42.0	D49.7
spinal	C70.1	C79.49	—	D32.1	D42.1	D49.7
areola	C50.0-☑	C79.81	D05-☑	D24-☑	D48.6-☑	D49.3
arm NEC	C76.4-☑	C79.89	D04.6-☑	D36.7	D48.7	D49.89
artery — *see* Neoplasm, connective tissue						
aryepiglottic fold	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
hypopharyngeal aspect	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
laryngeal aspect	C32.1	C78.39	D02.0	D14.1	D38.0	D49.1
marginal zone	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
arytenoid (cartilage)	C32.3	C78.39	D02.0	D14.1	D38.0	D49.1
fold — *see* Neoplasm, aryepiglottic						
associated with transplanted organ	C80.2	—	—	—	—	—
atlas	C41.2	C79.51	—	D16.6	D48.0	D49.2
atrium, cardiac	C38.0	C79.89	—	D15.1	D48.7	D49.89
auditory canal (external) (skin)	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
internal	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
nerve	C72.4-☑	C79.49	—	D33.3	D43.3	D49.7
tube	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
opening	C11.2	C79.89	D00.08	D10.6	D37.05	D49.0
auricle, ear — *see also* Neoplasm, skin, ear	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
auricular canal (external) — *see also* Neoplasm, skin, ear	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
internal	C30.1	C78.39	D02.3	D14.0	D38.5	D49.2
autonomic nerve or nervous system NEC (see Neoplasm, nerve, peripheral)						

HCPCS Level II Definitions and Guidelines

Structure and Use of HCPCS Level II

Codes

The main terms are in boldface type in the index. Main term entries include tests, services, supplies, orthotics, prostheses, medical equipment, drugs, therapies, and some medical and surgical procedures. Where possible, entries are listed under a common main term. In some instances, the common term is a noun; in others, the main term is a descriptor.

HCPCS Level II Codes: Sections A–V

Level II codes consist of one alphabetic character (letters A through V) and four numbers. Similar to CPT codes, they also can have modifiers, which can be alphanumeric or two letters. National modifiers can be used with all levels of HCPCS codes.

J Codes - Drugs

The table starting on this page identifies J codes common to medications/drugs used in oncology. They are usually injected/infused, but can be administered orally. They are generally not self-administered.

The Conventions: Symbols and Modifiers

Symbols used in the HCPCS Level II coding system may be presented in various ways, depending on the vendor. In this publication, the pattern established by the AMA in the CPT code book is followed.

For example, bullets and triangles signify new and revised codes, respectively.

When a code is new to the HCPCS Level II system, a bullet (●) appears to the left of the code. This symbol is consistent with the CPT coding system's symbol for new codes. The bullet represents a code never before seen in the HCPCS coding system.

Example

● J0893 Injection, decitabine (Sun Pharma) not therapeutically equivalent to J0894, 1 mg

A triangle(▲) is used (as in the CPT coding system) to indicate that a change in the narrative of a code has been made from the previous year's edition. The change made may be slight or significant, but it usually changes the application of the code.

Example

▲ J9041 Injection, bortezomib, 0.1 mg

In certain circumstances, modifiers must be used to report the alteration of a procedure or service or to furnish additional information about the service, supply, or procedure that was provided. In the HCPCS Level I (CPT) coding system, modifiers are two-digit suffixes that usually directly follow the five-digit procedure or service code. In HCPCS Level II, modifiers are composed of two alpha or alphanumeric characters that range from AA to VP.

HCPCS Code	Generic Name	Brand Name	FDA Approved Usage
J0185	Aprepitant, injection, 1 mg	Emend	Nausea and vomiting associated with chemotherapy
J8501	Aprepitant, oral, 5 mg	Emend	Nausea and vomiting associated with chemotherapy
J8597	Antiemetic drug, oral, not otherwise specified		
J9030	BCG live intravesical instillation, 1 mg	Tice BCG, PACIS BCG, TheraCys	Used in a solution to stimulate the immune system in the treatment of bladder cancer
J8510	Busulfan, oral, 2 mg	Busulfex, Myleran	Chronic myelogenic leukemia
J8515	Cabergoline, oral, 0.25 mg	Dostinex	Hyperprolacteria
J8520	Capecitabine, oral, 150 mg	Xeloda	Breast, colorectal cancer
J8521	Capecitabine, oral, 500 mg	Xeloda	Breast, colorectal cancer
J9070	Cyclophosphamide, 100 mg	cytoxan, Endoxan-Asta	Acute lymphoblastic leukemia, acute myeloid leukemia, breast cancer, chronic lymphocytic leukemia, chronic myelogenous leukemia, hodgkin lymphoma, muyeliptle myeloma, mycosis fungoides, neuoblastoma, non-Hodgkin lymphoma, ovarian cancer
J8530	Cyclophosphamide, oral, 25 mg	cytoxan	Acute lymphoblastic leukemia, acute myeloid leukemia, breast cancer, chronic lymphocytic leukemia, chronic myelogenous leukemia, hodgkin lymphoma, muyeliptle myeloma, mycosis fungoides, neuoblastoma, non-Hodgkin lymphoma, ovarian cancer
J9130	Dacarbazine, 100 mg	DTIC-Dome	Hodgkin lymphoma, melanoma

J9356

J9356 Injection, trastuzumab, 10 mg and hyaluronidase-oysk

Explanation

Trastuzumab and hyaluronidase-oysk (trade name Herceptin Hylecta™) is a combination of an IgG1 kappa monoclonal antibody (trastuzumab) and hyaluronidase-oysk, an endoglycosidase that increases the dispersion and absorption of co-administered subcutaneously injected drugs. Both drugs are produced using recombinant DNA technology from Chinese hamster ovaries and is indicated for the treatment of adults with HER2-overexpressing breast cancer. It is supplied as a colorless to yellowish solution in a single dose vial, providing 600 mg of trastuzumab and 10,000 units of hyaluronidase per 5 mL. The recommended dosage is 600 mg/10,000 units (600 mg trastuzumab and 10,000 unites hyaluronidase) administered by subcutaneous injection over two to five minutes, once every three weeks. There is no loading dose or adjustments required for patient body weight or adjuvant chemotherapy regimens. Care should be taken to ensure the proper drug is being administered. This drug is not the same as ado-trastuzumab emtansine.

Coding Tips

Report the appropriate administration code from the CPT code range 96401–96549. When the encounter is solely for the administration of chemotherapy, immunotherapy, or radiation therapy, assign the appropriate code from category Z51 Encounter for other aftercare and medical care, as the principal or first-listed diagnosis. The specific malignancy code is assigned and reported as an additional and secondary condition.

Documentation Tips

This substance is highly complex and requires direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight, and intraservice supervision of staff. Documentation should include the direct supervision, as well as special considerations for preparation, dosage or disposal, frequent monitoring, and any complications that occur. The documentation must indicate the substance, dosage, and administration.

Reimbursement Tips

Preauthorization of these services may be required. Check with the specific payer to determine benefits specific to cancer treatment, as well as with the patient regarding any supplementary cancer policies.

ICD-10-CM Diagnostic Codes

C50.011 Malignant neoplasm of nipple and areola, right female breast ♀ ☑
C50.012 Malignant neoplasm of nipple and areola, left female breast ♀ ☑
C50.021 Malignant neoplasm of nipple and areola, right male breast ♂ ☑
C50.022 Malignant neoplasm of nipple and areola, left male breast ♂ ☑
C50.111 Malignant neoplasm of central portion of right female breast ♀ ☑
C50.112 Malignant neoplasm of central portion of left female breast ♀ ☑
C50.121 Malignant neoplasm of central portion of right male breast ♂ ☑
C50.122 Malignant neoplasm of central portion of left male breast ♂ ☑
C50.211 Malignant neoplasm of upper-inner quadrant of right female breast ♀ ☑
C50.212 Malignant neoplasm of upper-inner quadrant of left female breast ♀ ☑
C50.221 Malignant neoplasm of upper-inner quadrant of right male breast ♂ ☑
C50.222 Malignant neoplasm of upper-inner quadrant of left male breast ♂ ☑
C50.311 Malignant neoplasm of lower-inner quadrant of right female breast ♀ ☑
C50.312 Malignant neoplasm of lower-inner quadrant of left female breast ♀ ☑
C50.321 Malignant neoplasm of lower-inner quadrant of right male breast ♂ ☑
C50.322 Malignant neoplasm of lower-inner quadrant of left male breast ♂ ☑
C50.411 Malignant neoplasm of upper-outer quadrant of right female breast ♀ ☑
C50.412 Malignant neoplasm of upper-outer quadrant of left female breast ♀ ☑
C50.421 Malignant neoplasm of upper-outer quadrant of right male breast ♂ ☑
C50.422 Malignant neoplasm of upper-outer quadrant of left male breast ♂ ☑
C50.511 Malignant neoplasm of lower-outer quadrant of right female breast ♀ ☑
C50.512 Malignant neoplasm of lower-outer quadrant of left female breast ♀ ☑
C50.521 Malignant neoplasm of lower-outer quadrant of right male breast ♂ ☑
C50.522 Malignant neoplasm of lower-outer quadrant of left male breast ♂ ☑
C50.611 Malignant neoplasm of axillary tail of right female breast ♀ ☑
C50.612 Malignant neoplasm of axillary tail of left female breast ♀ ☑
C50.621 Malignant neoplasm of axillary tail of right male breast ♂ ☑
C50.622 Malignant neoplasm of axillary tail of left male breast ♂ ☑
C50.811 Malignant neoplasm of overlapping sites of right female breast ♀ ☑
C50.812 Malignant neoplasm of overlapping sites of left female breast ♀ ☑
C50.821 Malignant neoplasm of overlapping sites of right male breast ♂ ☑
C50.822 Malignant neoplasm of overlapping sites of left male breast ♂ ☑
Z51.11 Encounter for antineoplastic chemotherapy

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
J9356	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
J9356	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
J9356	N/A	E	60(3)	N/A	N/A	N/A	N/A	None

* with documentation